# WA State Performance Measures Coordinating Committee
# October 31, 2014, 8:30 am – 12:00 noon
# Meeting Three – Meeting Summary

## *I. Welcome and Introduction*:

Nancy Guinto, Committee Co-Chair, welcomed attendees and thanked them for participating in the meeting. She reminded everyone of the Committee's legislative charge to develop a core measure set that will be used by state agencies, and on a voluntary basis, by other public and private purchasers and commercial payers. The Performance Measurement Committee provides direction to three technical work groups (acute care, chronic illness and prevention) that were charged with developing a final set of recommended measures. These final recommendations were presented for the Committee's consideration on October 31. After an opportunity for public comment during November, the Performance Measurement Committee will finalize the recommendations to HCA no later than December 17, 2014.

Ms. Guinto stressed the importance of keeping this a transparent process, allowing for public input and opportunities for participation, sharing all meeting materials and summaries on the Healthier WA website at: http://www.hca.wa.gov/hw/Pages/performance_measures.aspx.

### *Review/Discuss Workgroups' Recommendations for "Starter Set" of Measures:*

After acknowledging the contributions of Bailit Health Purchasing, Washington Health Alliance, and the Health Care Authority to complete this work, Susie Dade, Deputy Director with the Washington Health Alliance, gave a brief overview of the process used by the three technical workgroups to develop a final set of recommended measures. Ms. Dade then took the Committee through a contextual framework to show how the measures relate to strategies leading to improved results. After providing a brief explanation on the recommendations report, she explained how the three types of measures—population health, clinical measures, and cost measures—will be implemented using different data sources and various units of analysis.

Performance Measures Final Draft Recommendations

- During Ms. Dade's review of the recommended measures, she discussed several pressure points or areas of concern (Slide 24) that the workgroups faced during their deliberations. These can be summarized as follows:
    - Lack of a standardized and reliable mechanism to access clinical data for robust statewide measurement and public reporting
    - Accessing data related to behavioral health and sexually transmitted diseases due to privacy concerns among data suppliers
    - Small "N" concerns that will limit participation for some critical access hospitals, small medical groups and rural counties
- In addition, Ms. Dade discussed some potential challenges that the state may encounter in implementing the measure set. These include:

- Sufficient funding to routinely implement patient experience surveys, permitting publicly reportable results at the clinic and medical group levels statewide
- Resources within the Department of Health to produce immunization results at the medical group level (Childhood, Adolescent, HPV, Pneumonia)
- Time and resources to program and validate those measures that are not in use today (e.g., psychiatric inpatient readmission; medication adherence; oral health; health care costs)

- Ms. Dade also took time to discuss the recommendation to include measures related to generic prescribing, noting that this topic received more attention than any other in terms of feedback to the workgroup. Ms. Dade noted that the workgroup agrees that the overall rate of generic prescribing is relatively good and has improved significantly over the past few years. However, she also noted that there is still significant variation among medical groups and individual prescribers within medical groups, suggesting there is still significant room for improvement in this area.

**Committee comments/suggestions by themes:**

The Committee engaged in a lengthy discussion of the recommended measures. Their comments and suggestions are summarized below.

Size of measure set:

- Some expressed concern that with a "starter" set of 53 measures and advocated for a parsimonious list. It might be more useful to have a larger number of entities focusing on a smaller number of measures.
- It may be useful to cluster the measures by topic so the list will be less overwhelming.
- The size of the measure set is daunting however it does get much smaller when you focus on a particular area, such as hospitals, obstetrics or pediatrics.
- Some noted that a list of 53 measures will be a significant improvement over the hundreds of measures now being used by multiple public and private payers to track performance.

Measures selection:

- Efficacy is the main thing we should focus on, making sure the measures selected will help to shape desired behavior change and contribute to performance improvement efforts.
- It is important that we clearly identify what our intended outcomes are and if these measures are replicable by setting and if not make sure there's a mechanism to help link them.
- Stratifying results by commercial versus Medicaid will be important given differences in the populations and a desire to not penalize those providers who serve a disproportionately larger share of patients who are insured via Medicaid. It was discussed that the plan is to show results separately. The right-hand column of pages 7-10 identifies the measures that will be stratified and how.

- A question was raised regarding why claims data are being used to measure hospital readmissions rather than using CHARS data. It was discussed that the particular measure in question, NCQA HEDIS 30-day all cause readmissions, relies upon claims data; this measure is quite complex to program due to the risk adjustment and the Alliance has already invested considerable resource in the programming.
- A question was raised whether the prevalence of obesity, as a population health measure, was considered, as we do not have a good measure that addresses childhood obesity. Two measures were originally on the recommended list, including (1) the percentage of adults with a healthy weight (data source: BRFSS), and (2) the percentage of adolescents with a healthy weight (data source: Healthy Youth Survey). The Prevention Workgroup ultimately recommended removing these two measures from the recommended list largely because we had already surpassed our target number of measures and the list does include two other BMI measures. It was noted that when using claims data for obesity we are not capturing all of the population as some are not routinely utilizing the health care system. It was also noted that the Department of Health will continue to implement BRFSS and the HYS, so this prevalence data will be available to the state on an ongoing basis.
- One Committee member noted we are doing well with generic fill rate and will never reach 100% as generics are not always right for patients. A concern was raised about requiring providers to always use generic first, even if it may not be the best option for the patient. It was discussed that none of the generics measures includes target performance of 100% for this very reason.
- It will be important to measure access (adult, children/adolescents) by payer type and by health plan. In particular, there is a desire to track access due to the Medicaid expansion and concerns regarding network adequacy.
- Some mentioned that the starter set contains a lot of measures that address chronic conditions. While they may be good proxy measures for now, it will be important to stratify the data to understand the specific needs of the behavioral health population going forward. Also, future iterations of the measure set should focus more specifically on behavioral health as our ability to reliably measure in these area is further developed.
- It was noted that the measures on the recommended starter set are mostly familiar and reporting of some of these measures has been going on for years. We will want to continually think about efficacy and whether continued measurement and reporting in these areas is helping us achieve our goals.

The Committee also briefly discussed the plan for implementation of measures set:

- It was suggested we consider a small study/sample test to early identify any potential test result issues
- Question was asked about how we prioritized 53 measures going forward.–The group discussed focusing on cost and impact on quality rather than prioritizing the measures.
- We need to identify next steps to clearly identify what our priorities are.

- The group discussed the potential implementation of a dashboard as the measures set is modified and updated where information will be available to ensure public access to data.

### *II. Review/Discussion for High Priority Development Opportunities:*

- Ms. Dade reviewed the topics that the workgroups placed on the High Priority Development Agenda (sometimes referred to as "the Parking Lot" for shorthand) and highlighted the order of priority that the committee and workgroups placed them in, using a tiered structure.
- She stressed that the statewide core measures set will NOT eliminate other ongoing measurement efforts in Washington, as it's expected these efforts will continue.

### *III. Public Comment*

- Deb Doyle, Department of Health, offered her appreciation for the comments from the Committee members, including "what gets measured gets done." She noted that the current measures are very adult-focused and if we want to save costs down the road we need focus on behavioral health and other adult and children measures, thinking about preventing chronic disease down the road.
- Jenny Arnold, Washington State Pharmacy Association shared that she is the chair for the Washington State Immunization Action Coalition wanted to thank the workgroups and Committee for including immunizations across the life span. She stated that it is bold and it addresses health across the lifespan.
- Robin Fleming, Office of Superintendent of Public Instruction commented that learning is linked to health status so we need to ensure better health. She stated that the school nursing system is already doing a lot of the work, e.g. prevention, immunizations, and that pushing that system and measuring the outcomes already taking place would be important and is something to collaborate on.
- Edward Fox, Upper Skagit Indian Tribe (filling in for Marilyn Scott), offered the suggestion that the state consider how we will support smaller providers to do this work.

### *IV. Committee Action*

The discussion of the proposed measures wrapped up with Dorothy Teeter, HCA Director, summarizing the high level discussion points and reminding the Committee that next steps are to release the recommendations for public comment from November 4 – 21. The workgroups will meet one more time in early December, and taking the Committee's discussion points into consideration, along with public comments and survey results will incorporate them into final recommendations for approval at the December 17 meeting.

Ms. Guinto solicited any additional recommendations from the Committee before voting:

- Suggestion was put forward to be thoughtful on how we communicate the measure set, as they represent areas where we have gaps and consider how to engage people in the process
- Consideration should be given to how we address small rural practices. Carol Wagner offered to assist with bringing together rural health to work on this.

After a brief discussion, Ms. Teeter asked the Committee to finalize and take action to release the recommendations for public comment.

**Actions:**

1. The Committee unanimously voted to release the draft set of recommended measures for public comment.
2. The recommendations, along with a link to a brief survey will be released to the public from November 4-21.*

*Please send any additional comments to Laura Pennington.

***V. Process for Review and Modification of Measure Set over Time:***

Laura Kate Zaichkin, Health Care Authority, reminded the Committee of E2SHB 2572, which charges the Committee with establishing a public process to periodically evaluate the measures set, modifying as needed. This includes consideration of how to address the High Priority Development Agenda going forward. The Committee began the discussion by offering recommendations that addressed the following questions:

1. What are criteria that should be considered when prioritizing the addition of measures on the High Priority Development Agenda?

    - Is the measure/topic called out in legislative priorities or actions
    - Do we have the ability to measure
    - Causality - does the measure prevent a health condition from occurring in the first place
    - Does the measure require shared-responsibility to accomplish, for example care transitions or population and behavioral health
    - Does the measure address an urgent public health issue
    - Measure should be actionable
    - Does the measure address a gap, cost driver and/or critical safety factors

2. What are things to consider when developing a process for identifying appropriate measures?

    - We need a source to identify gaps and focus on opportunities and where there is consensus on problems in practice
    - We should identify what we are trying to change and be cautious with changing too much too soon
    - We need to look at what is working and isn't before adding more, monitor unintended consequences and be responsive
    - Consider pace of change, needed resources and work involved to implement new measure
    - Consider impact on rural communities, keeping pace with rural efforts
    - Consider the work of others and prioritize commonly agreed upon measures and approaches, as well as legislative mandates, connecting the dots between activities
    - Align with timing of national measure initiatives, be proactive in monitoring and responding to change in evidence

- We need to partner with others to "innovate" and look beyond nationally vetted measures
- We should not assume impact on specific population
- Consider 80/20 rule when prioritizing

3. How should the workgroups and PMCC be structured going forward?

    - PMCC is an appropriate group for policy and communication, as skills are different from those needed for workgroups. Committee size needs to be manageable
    - Lead organization needs to be involved in development of process and to continue to convene ongoing work of committee and public process
    - Understanding that the current workgroups will most likely not continue, we need additional workgroup structures:
        - Implementation workgroup
        - Workgroup to review parking lot measures
        - Data analyses workgroup, with oversight from HCA to review what is working
        - Policy workgroup
    - The workgroups should be topic specific, consisting of subject matter experts

4. Other

    - Consider how to report on population who may be getting care from bordering states

## *VI. Public Comment*

BJ Cavnor, 1 in 4 Chronic Health, commented by telephone that he would like to recommend the removal of the generic fill rate measure, supporting the comments of NAMI members that generic alternatives for psychiatric patients may not always be appropriate.

## *VII. Next Steps*

1. Recommendations and survey will be sent out for public comment.
2. Workgroups will meet in early December to review results and submit recommendations to Committee members for review prior to the December meeting.
3. The measure set will be finalized at the December 17, 2014 meeting.

*Committee Members Present*:

Dorothy Teeter, Co-Chair, Washington State Health Care Authority (HCA)
Nancy Guinto, Co-Chair, Washington Health Alliance
Chris Barton, SEIU Healthcare 1199NW
Jane Beyer, Washington State Department of Social and Health Services
Craig Blackmore, Virginia Mason Medical Center
Gordon Bopp, NAMI - Washington
Patrick Bucknum, Columbia Valley Community Health
Frederick Chen, University of Washington Medicine
Ann Christian, Washington Community Mental Health Council
Victor Collymore, Community Health Plan of Washington
Patrick Connor, National Federation of Independent Businesses
Jessica Cromer, Amerigroup Washington
Sue Deitz, Critical Access Hospital Network of Eastern Washington
John Espinola, Premera Blue Cross
Gary Franklin, Labor and Industries *(by phone)*
Ann Hirsch, Seattle University
Larry Kessler, UW School of Public Health, Department of Sciences
Byron Larson, Urban Indian Health Institute
Dan Lessler, Health Care Authority
Kathy Lofy, Washington State Health Department
Susie McDonald, Group Health Cooperative
Julie McDonald, Providence Regional Medical Center Everett
Sheri Nelson, Association of Washington Business
Mary Kay O'Neill, Regence Blue Shield
Scott Ramsey, Fred Hutchinson Cancer Research Center
Charissa Raynor, SEIU Healthcare NW Training Partnership/Health Benefits Plus
Dale Reisner, Washington State Medical Association
Marguerite Ro, Public Health – Seattle and King County
Rick Rubin, OneHealthPort
Torney Smith, Spokane Regional Health District
Jonathan Sugarman, Qualis Health *(by phone)*
Carol Wagner, Washington State Hospital Association

*Committee Members Absent:*

Teresa Fulton, Western Washington Rural Health Collaborative
Marilyn Scott, Upper Skagit Indian Tribe (Edward Fox called in on her behalf)

*Additional Participants:*

*Bob Crittenden, Governor's office*
*Nathan Johnson, Health Care Authority*
*Laura Zaichkin, Health Care Authority*
*Laura Pennington, Health Care Authority*
*Rachel Quinn, Health Care Authority*

*Lena Nachand, Health Care Authority*
*Additional Participants continued:*

*Susie Dade, Washington Health Alliance*
*Teresa Litton, Washington Health Alliance*
*Michael Bailit, Bailit Health Purchasing (by phone)*
*Beth Waldman, Bailit Health Purchasing (by phone)*
*Edward Fox(substituting for Marilyn Scott by phone)*
*Deb Lochner Doyle, Department of Health*
*Mary Beth Brown, Washington Association of Community and Migrant Health Centers*
Kara Panek, Washington State Department of Social and Health Services
*Jenny Arnold, WA State Pharmacy Association*
*Craig Sexton, GlaxoSmithKline*